STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155243	B. WIN			04/20/20)11
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	NDY HILL DRIVE		
REGENO	CY PLACE OF LAFA	YETTE		1	ETTE, IN47905		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r the investigation of	F0	000			
	complaint number	er IN00088759					
	Complaint numb	er IN00088759					
	•	ederal/State deficiencies					
		egations are cited at F223					
	and F225.	- O are vived at 1 220					
	and 1 223.						
	Survey dates: Ap	oril 18, 19 & 20, 2011					
	Facility number:	000147					
	Provider number						
	AIM number: 10						
	Allyl Hullioci. 10	0200900					
	Survey Team:						
		DNI TC					
	Linda Campbell,	KN, IC					
	Census Bed Type	z.					
		139					
	Total: 139	13)					
	10181. 139						
	Cangua Davian T-	no:					
	Census Payor Ty	pe.					
	Medicare: 30						
	Medicaid: 86						
	Other: 23						
	Total: 139						
	Sample: 9						
	Those deficient	es also reflect state					
	_	accordance with 410 IAC					
	16.2.						
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE	•	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: 000147

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155243	B. WIN	G		04/20/20	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REGENO	CY PLACE OF LAFA	YETTE	300 WINDY HILL DRIVE LAFAYETTE, IN47905				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re	COMPLETION
F0223 SS=B	Quality review of 2011 by Bev Fau The resident has a verbal, sexual, ph corporal punishments seclusion. The facility must resevual, or physical punishment, or involved and record reversal facility fauresidents abuse related abuse and misappropresident punishments or involved and the security fauresidents abuse and misappropresident punishments abuse and misappropresident punishments or involved and the security fauresidents abuse and misappropresident punishments abuse and misappropresident punishments abuse in a security fauresident punishments abuse and misappropresident punishments abuse and misappropresident punishments abuse in a security fauresident punishments abuse and misappropresident punishments abuse in a security fauresident punishments abuse in a security fauresident punishments abuse and misappropresident punishments abuse abuse and misappropresident punishments abuse and misappropresident punishments abuse abuse abuse abuse abuse abuse abuse and misappropresident punishments abuse abus	the right to be free from sysical, and mental abuse, ent, and involuntary of use verbal, mental, labuse, corporal voluntary seclusion. interview and view, the filed to ensure were free from ated to verbal oriation of roperty for 3 of s reviewed for sample of 9. s D, G, H).	F0	223	F 223What corrective action will be accomplished for the residents found to have been affected by the deficient practice? The facility follow policy and procedure for identifying, reporting and investigating allegations of a for Residents D, H and G. Appropriate disciplinary action include termination of employ for substantiated abuse was conducted per policy. 1. Resident D's report was investigated according to fact policy and substantiated. The employee was discharged. Resident D discharged from Regency Place on 3/29/11 2 C.N.A. #5 reported the incident involving resident H immedia The incident was investigate substantiated. Employee C. #6 was terminated. 3. The facility immediately began ar investigation upon notification the incident regarding resident C.N.A. #7 was terminated. He other residents having the	en ed its buse on to yees cility ne cent ately. d and N.A. n n of nt G.	04/24/2011

000147

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	155243	A. BUII		00	04/20/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	- ,
NAME OF P	ROVIDER OR SUPPLIER				NDY HILL DRIVE	
REGENO	Y PLACE OF LAFA	YETTE			ETTE, IN47905	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	potential to be affected by t	DATE he
	1. A "Fax/	Incident			same deficient practice will	be
	Reporting	Form" dated			identified and what correcti action(s) will be taken All	ve
	3/30/11 in	dicated "On			residents have the potential affected. What measures wi	
	3/29/11 in	the early			put in place or what system changes will be made to	iic
	morning (Resident D's			ensure that the deficient practice does not occur St	aff
	name) cor	nplained that			has been re-educated on the policy and procedure for abu	
	she was yo	elling out				
	several tin	nes and wanted			protecting the resident and investigating. How the corrective action(s) will be	
	someone t	to help her to			monitored to ensure the deficient practice will not re	acur
	her recline	•			i.e. what quality assurance program will be put into pla	
	several tin	nes of yelling			Staff will be randomly (1 sta member per shift, 3 times	
		#1's name)			weekly)questioned regarding abuse policy. Administrator	the
	`	nd told her if			and/or designee will report findings to the Performance	
		(sic) not quiet			Improvement team monthly three months and then quart	I
		would cover			to ensure ongoing compliance. Residents will	
	her face w				randomly questioned (interviewable residents 4 pe	
	nebulizer				shift, 3 times weekly) regarding staff treatment of residents.	I
		D) stated that			Administrator and/or designer report findings to the	ee to
		orried the rest			Performance Improvement to monthly for three months and	
					then quarterly to ensure ong	oing
	or the mgi	nt and about			compliance. Findings and sy components will be reviewed	I
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	 U0CV11	Facility I		•

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		· ·	ĺ		INSTRUCTION 00	(X3) DATE S COMPL	
		155243	A. BUI B. WIN	LDING IG		04/20/20	011
NAME OF F	PROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE	•	
REGENO	CY PLACE OF LAFA	YETTE		1	ETTE, IN47905		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	being kick	ked out of the			the Performance Improveme Team with subsequent plan		
	facilityCNA was placed on administrative				correction developed and implemented as deemed		
					necessary.		
	leave imm	•					
	pending th	ne					
	investigat	ionthe					
	complaint	was					
	substantia	ted and (CNA					
	#1's name) was					
	terminated	d on 4/4/11"					
		_					
	A handwr	itten statement					
	signed by	RN #2					
	indicated	"(CNA #3)					
	stated that	(Resident D)					
	just said s	he was scared					
	and the sh	ort red hair girl					
	had threat	ened her					
	saying tha	t she would be					
	, ,	t if she didn't					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155243		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/20/2011	
	PROVIDER OR SUPPLIER		300 WI	ADDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE ETTE, IN47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
	stop coug	hing and take			
	her breath	ing treatment.			
	By short h	nair, red hair c			
	(with) gla	sses meaning			
	(CNA #1)	So (RN #4)			
	went to as	k (Resident D)			
	what happ	ened. (RN #4			
	came back	and said the			
	same state	ement"			
	signed by indicated asked (CN her chair. her she co the shift, I (Resident was upset	itten statement CNA #3 "(Resident D) NA #1) to get in (CNA #1) told ouldn't. Later in answered D's) light. She told me that ith short red			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155243	B. WING		04/20/2011
NAME OF I	PROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE INDY HILL DRIVE	
REGENO	CY PLACE OF LAFA	YETTE	I	ETTE, IN47905	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	hair and g	lasses had told			
	her if she	didn't stop			
	coughing	she would send			
	her out of	here. I didn't			
	hear any c	of that. I did			
	hear (CNA	A#1) tell her			
	she could	n't get in her			
	chair"				
	Resident I	D's closed			
	clinical re	cord was			
	reviewed	on 4/19/11 at			
	5:15 A.M.	. The record			
	indicated	the resident			
	was admit	tted with			
	diagnoses	which			
		but were not			
		, syncope and			
	ĺ	chronic kidney			
	1 1	•			
	disease, a	iiu			
				!	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE S COMPL	
		155243	B. WIN	G		04/20/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE		
REGENO	Y PLACE OF LAFA	YETTE		I	ETTE, IN47905		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE .	DATE
	hypertensi	ion.					
	A Minimu	ım Data Set					
	(MDS) 30	-day					
	assessmen	nt, dated					
	2/22/11, in	ndicated the					
	resident w	as moderately					
	impaired i	n cognitive					
	decision-n	naking skills,					
	had poor a	appetite, and					
	required e	• •					
	•	n physical					
	assistance	1 3					
	mobility. 1	transfer, and					
	toilet use.						
	101101 450.						
	Δ nurses' i	note, dated					
		,					
		3:30 A.M.,					
		"Pt (patient)					
	verbalizes	that 'short red					

000147

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE : COMPL		
		155243	B. WIN	IG		04/20/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE		
REGENO	CY PLACE OF LAFA	YETTE		1	ETTE, IN47905		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	hared (sic)) girl with					
	glasses to	ld me I'm					
	keeping ev	veryone awake					
	and threat	ened to kick					
	me out of	here.' Pt is					
	alert and o	oriented(CNA					
	#1) says 'I	asked her to					
	please use	the call light					
	because he	ollering is					
	keeping ro	oommate					
	awake and	d assured call					
	light withi	in reach.'"					
	A social so	ervice note,					
	dated 3/29	9/11 at 12:15					
	P.M., indi	cated "F/U					
	(follow up	o) conversation					
	c (with) re	esident about					
	incident c	(with) CNA					
	last night.	she states					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE S COMPL		
		155243	B. WIN	G		04/20/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE		
REGENO	CY PLACE OF LAFA	YETTE		1	ETTE, IN47905		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	after sever	ral episodes (of					
	resident y	elling) CNA					
	came in a	nd told her that					
	if she didr	n't quiet down					
	she would	cover her face					
	c (with) no	ebulizer mask.					
	Resident s	states she did					
	not sleep t	the rest of night					
	and was w	vorried about					
	being kick	xed out"					
	An emplo	yee file for					
	CNA #1 w	vas reviewed					
	on 4/19/11	1 at 5:20 A.M.					
	A "Perform	mance					
	Improvem	nent Form,"					
	dated 8/20	0/09, indicated					
	"CNA was	s short/rude					
	with a resi	ident. Res					
	(resident)	asked for					
	,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155243		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 04/20/2	LETED	
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE ETTE, IN47905	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE	
	coffee, CN	NA told res that					
	coffee was	sn't important,					
	she had pe	eople to get					
	upFinal	written					
	warning (indicated by					
	X)any fi	urther					
	problems R/T (related to)						
	rudness (s	ic) to residents					
	could resu	ılt in					
	termination	on"					
	A "Perform	mance					
	Improvem	nent Form,"					
	dated 4/4/	11, indicated					
	"allegati	ion of verbal					
	abuse from	n (Resident					
	D)seper	ation (sic) due					
	to allegati	on of					
	abusesu	bstantiateddis					
	charge (in	dicated by					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155243	A. BUII B. WIN			04/20/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE		
REGENO	Y PLACE OF LAFA	YETTE		1	ETTE, IN47905		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	IOULD BE COMPLET	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	X)						
	Interview	on 4/18/11 at					
	12:30 P.M	I., with the					
	DNS (Dire	ector of					
	Nursing S	ervices)					
	indicated	the resident					
	had told to	wo nurses and					
	a CNA tha	at CNA #1 said					
	she would	be kicked out					
	of the faci	lity and a mask					
	would be	put over her					
	face. She	indicated the					
	stories we	re "consistent."					
	She indica	nted Resident D					
	was fright	ened but was					
	assured C	NA #1					
	wouldn't t	ake care of her					
	again. The	e DNS					
	indicated	CNA #1 did					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED	
AND FLAIN	OI CORRECTION	155243	A. BUII B. WIN		00	04/20/2011
NAME OF F	PROVIDER OR SUPPLIER		P. WIII	STREET A	ADDRESS, CITY, STATE, ZIP CODE	l
	CY PLACE OF LAFA			1	NDY HILL DRIVE ETTE, IN47905	
(X4) ID		TATEMENT OF DEFICIENCIES	\neg	ID	· [(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		in the building		TAG	SERIES (1)	DATE
		llegation and				
	was termi	U				
l	4/4/11.					
	-, -,					
	2. A "Fax	/Incident				
	Reporting	Form," dated				
		indicated "				
		came to DNS				
	office and	reported				
	during the	change of				
	shift, (CN	A #6) and				
	herself we	ere transferring				
	(Resident	H) to bed.				
	(CNA #6)	was				
	complaini	ng about the				
	day and (I	Resident H)				
	attempted	to ask (CNA				
	#5) and (C	CNA #6)				
	something	g. (CNA #6)				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155243		LDING	NSTRUCTION 00	(X3) DATE COMPL 04/20/2	ETED	
	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE ETTE, IN47905	<u> </u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	told (Resi	dent H) to 'shut				
	up' and ac	ted like she				
	was going	to slap the				
	back of hi	s head. (CNA				
	#5) report	ed the incident				
	immediate	ely. (CNA #6)				
	was place	d on				
	administra	ative leave				
	immediate	ely(CNA #6)				
	was termi	nated and DNS				
	explained	to her				
	behavior v	was				
	inappropr	iate"				
	A typewri	tten statement,				
		3/11, indicated				
		#5) and I were				
	caring (sig	,				
	 	ion among each				
		(Resident H)				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155243		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 04/20/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 WINDY HILL DRIVE LAFAYETTE, IN47905					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	repeated s	omething						
	actually m	numbled						
	something	g. I looked at						
	him and s	aid oh be quiet.						
	It's ok we	re (sic) going						
	to lay you	down"						
	An undate	ed handwritten						
	statement	signed by						
	CNA #5 i	ndicated "she						
	was trying	g to explain the						
	drama of	her day to me						
	as we wer	e getting						
	(Resident	H) ready to lay						
	down. He	was trying to						
	speak and	she said 'shut						
	up' though	n him trying to						
	talk. Then	she raised her						
	hand as if	to back hand						
	him. She	was behind him						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED	
		155243	A. BUII B. WIN			04/20/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE	
REGENO	CY PLACE OF LAFA	YETTE		1	ETTE, IN47905	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	so he coul	dn't see. I told				
	her that w	asn't right, that				
	I didn't wa	ant to hear the				
	gossip. I'n	n sure she				
	wouldn't h	nave actually				
	hit him, al	thou (sic) it				
	was a very	y cruel				
	gesture"					
	Resident I	H's closed				
	clinical re	cord was				
	reviewed	on 4/19/11 at				
	7:10 A.M.	. The record				
	indicated	the resident				
	was admit	tted with				
	diagnoses	which				
	included, but were not limited to, senile					
		_				
	dementia, pneumonia,					
	and chron	ic airway				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155243		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155243	B. WING	ADDRESS, CITY, STATE, ZIP CODE	04/20/2011
	PROVIDER OR SUPPLIER		300 W	INDY HILL DRIVE	
	CY PLACE OF LAFA			'ETTE, IN47905	aro.
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	obstructio	n.			
	A MDS as	ssessment,			
	dated 12/1	6/10, indicated			
	the resider	nt was severely			
	impaired i	n cognitive			
	decision-r	naking skills,			
	had long-	and short-term			
	memory p	roblems, and			
	required e	extensive			
	one-perso	n physical			
	assistance	for bed			
	mobility,	transfer, and			
	toilet use.				
	An emplo	yee file for			
	CNA #6 w	vas reviewed			
	on 4/19/11	1 at 5:00 A.M.			
	Document	tation was			
	lacking re	lated to any			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 04/20/2	ETED	
	PROVIDER OR SUPPLIER			300 WIN	DDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE ETTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	previous e	episodes of					
	abuse by the CNA.						
	Interview 12:30 P.M. DNS indicated that told the resider indicated no previous abuse by the second of the second o	on 4/18/11 at I. with the cated the CNA terminated for use. The CNA ne resident to but had not hit nt. She there had been us incidents of the CNA.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	00	COMPI		
		155243	B. WIN			04/20/2	2011
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE NDY HILL DRIVE		
REGENO	CY PLACE OF LAFA	AYETTE		1	ETTE, IN47905		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E	(X5) COMPLETION
TAG	_	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	WAI L	DATE
	transferre	d from					
	Regency 1	Place of					
	Lafayette	to (hospital					
	name)(F	Resident G's)					
	wife (nam	ne) and her					
	mother (n	ame) came in					
	to get (4)	\$40 gift cards					
	from (Res	sident G's)					
	wallet tha	t he had					
	purchased	l earlier in the					
	month. (R	Resident G's)					
	wallet wa	s locked in the					
	med cart v	with \$23 cash,					
	his bank c	eard and his					
	receipt for	r the gift cards.					
	The 4 gift	cards were not					
	in his wal	let. The wife					
	and mothe	er-in-law					
	searched his items with						
	staff assis	tance, no gift					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243			LDING	NSTRUCTION 00	l` ´	e survey pleted /2011	
NAME OF I	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP COI NDY HILL DRIVE	DE .	
REGENO	CY PLACE OF LAF	AYETTE		1	ETTE, IN47905		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	cards wer	e found. The					
	wife and	mother-in-law					
	then went	to Walmart					
	and Walm	nart stated the					
	cards wer	e spent at the					
	(name of	city) Walmart					
	at 0330 (3	3:30 A.M.) on					
	12/11/10.	The wife and					
	mother-in	ı-law did make					
	a police re	eport and					
	would have	ve been able to					
	watch the	surveillance					
	tapes on I	Monday. While					
	the wife a	and					
	mother-in	a-law were at					
	Regency	Place on					
	12/18/10	they were					
	discussing	g the issue at					
	the desk v	with the staff.					
	The DNS	was notified at					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		NSTRUCTION 00		(X3) DATE : COMPL	
11.212111	22 201111211	155243	A. BUI B. WIN	LDING G			04/20/2	
NAME OF F	PROVIDER OR SUPPLIER		P. 112		DDRESS, CITY, STA	TE, ZIP CODE		
	Y PLACE OF LAFA			1	NDY HILL DRIVE ETTE, IN47905			
(X4) ID		TATEMENT OF DEFICIENCIES		ID I				(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIV CROSS-REFERENCE	LAN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	COMPLETION
TAG	this time a	and an		TAG	DEF	ICIENCI)		DATE
	investigati	_						
		mmediately.						
		•						
	, i	overheard the						
	discussion	and later in						
	the shift re	eported to						
	(LPN #8)	that he had						
	'spent the	gift cards.'						
	(CNA #7)	told (LPN #8)						
	that he 'fo	und them in						
	the showe	r room,' he						
	knew that	they were not						
	his and he	spent them.						
	(LPN #8)	immediately						
	notified th	ne DNS and						
	(CNA #7)	was placed on						
	`	rative Leave						
	immediate	ely. (LPN #8)						
	and (CNA	47) also						
	notified th	ne police and he						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	 U0CV11	Facility I	D: 000147	If continuation sh	neet Par	ge 20 of 32

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243			LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 WINDY HILL DRIVE LAFAYETTE, IN47905					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	was arrest	ed for theft on						
	12/18/10 a	at 2100 (9:00						
	P.M.)(C	NA #7) was						
	terminated	d on 12/20/10.						
	DNS cont	acted the						
	police and	l made a						
	statement.	" The facility						
	reimburse	d the resident						
	for the \$1	60 gift cards.						
	Resident (G's clinical						
	record wa	s reviewed on						
	4/18/11 at	11:55 A.M.						
	The record	d indicated the						
	resident w	as admitted						
	with diagr	noses which						
	included,	but were not						
	limited to	, necrotizing						
	facieitis, s	acral						
	decubitus,	diabetes						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		155243	B. WIN			04/20/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REGENO	CY PLACE OF LAFA	YETTE		LAFAYE	ETTE, IN47905		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	mellitus, p	osych					
	(psycholo	gical) disorder,					
	and histor	y of pulmonary					
	embolus.						
	An MDS:	5-day					
	assessmen	nt, dated					
	3/30/11, ii	ndicated the					
	resident w	as independent					
	in cognitiv	ve					
	decision-r	naking skilled,					
	was totally	y dependent on					
	•	n physical					
	•	bed mobility,					
	and was to						
		t on one-person					
	•	•					
		ssistance for					
	toilet use.						
	Interview	on 4/19/11 at					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155243		(X2) MULTIPLE A. BUILDING B. WING	00	COM	TE SURVEY MPLETED D/2011	
	PROVIDER OR SUPPLIER		300 V	T ADDRESS, CITY, STATE, ZIP WINDY HILL DRIVE YETTE, IN47905	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	7:35 A.M	., with Resident				
	G indicate	ed the resident				
	had four \$	340 gift cards in				
	his wallet	. He went to				
	the hospit	al and his wife				
	and mothe	er-in-law came				
	to the faci	lity to pick				
	them up.	They were				
	gone. He	indicated "the				
	CNA knev	w they were				
	there beca	use I had				
	asked him	to get \$10				
	from my v	wallet before."				
	He indicate	ted he had no				
	previous p	problems with				
	theft at the	e facility.				
	CNA 7's e	employee file				
	was reviev	wed on 4/19/11				
	at 4:40 A.	M. A				

000147

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155243		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE: COMPL 04/20/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 WINDY HILL DRIVE LAFAYETTE, IN47905					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	"Performa	nnce						
	Improven	nent Form"						
	dated 12/2	20/10 indicated						
	"(1) alle	gation of theft						
	substantia	ted. (2) facility						
	did reimb	urse \$160was						
	arrested for	or theft et (and)						
	on Walma	rt video"						
	A criminal history check, dated 4/28/09, indicated CNA #7 had two misdemeanor charges for operating a vehicle while intoxicated in 2004. One charge was dismissed and the other had no resolution available for review.							

AND PLAN OF CORRECTION IDENTIFICATION NO		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE S	ETED
		155243	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/20/2	UII
NAME OF F	PROVIDER OR SUPPLIER			1	NDY HILL DRIVE		
REGENO	REGENCY PLACE OF LAFAYETTE			LAFAYE	ETTE, IN47905		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Document	tation was					
	lacking re	lated to any					
	previous o	occurrences of					
	theft.						
	Interview on 4/18/11 at						
	12:30 P.M., with the						
	DNS indic	cated Resident					
	G's family	had come to					
	get the gif	t cards. The					
	CNA told	a nurse he had					
	taken then	n. The family					
	went to th	e police and					
	the CNA v	was arrested					
	for theft. The CNA was seen on camera spending them. The DNS						
	indicated	there had been					
	no previou	is issues					
	related to	theft and the					

l li		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243	(X2) MULTIPLE C	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/20/2011
NAME OF F	PROVIDER OR SUPPLIER			CADDRESS, CITY, STATE, ZIP CODE	0.120.20.11
REGENO	CY PLACE OF LAFA	YETTE	l l	/ETTE, IN47905	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	family wa	s reimbursed.			
	The CNA	was			
	terminated	d.			
	Review or	n 4/18/11 at			
	1:15 P.M.	, of a facility			
	policy and	d procedure,			
	dated 7/11	/10, provided			
	by the Sta	.ff			
	Developm	nent			
	Coordinat	or, and titled			
	"Respond	ing to and			
	Investigat	ing an Abuse			
	Allegation	n" indicated			
	"For All Abuse AllegationsCall the police, if required by law and follow their instructions if there is an				
	alleged:	Theft of			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155243	B. WING		04/20/2011		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 WINDY HILL DRIVE				
	CY PLACE OF LAFA			/ETTE, IN47905			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	_	ropertyIf					
		s against an					
	employee						
	substantia	ted, a.					
	terminate	employment"					
	Review on 4/18/11 at						
	1:15 P.M. of a facility						
	policy and	l procedure,					
	dated 4/28	8/09, provided					
	by the Sta	_					
	Developm	nent					
	Coordinat	or, and titled					
	"Protection of Resident During an Investigation" indicated "A staff member(s) implicated in an abuse/neglect situation, regardless of						
		C					
	aiscipiile,	, will be: a.					
	!						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155243			LDING	00	COMPI 04/20/2	LETED	
	NAME OF PROVIDER OR SUPPLIER REGENCY PLACE OF LAFAYETTE			STREET A	NDY HILL DRIVE	1	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	immediate	ely removed					
	from any	resident					
	contact. b	. interviewed					
	and versic	on of event					
	document	ed. c.					
	suspended	l pending					
	investigat	ion results.					
	3.1-9(b)						
	3.1-27(b)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	155243	A. BUILDING	04/20/2011	
			B. WING	DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		l	NDY HILL DRIVE	
	CY PLACE OF LAFA		LAFAYE	ETTE, IN47905	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F0225		ot employ individuals who	IAG		DATE
SS=D	or mistreating residual have had a finding nurse aide registry	guilty of abusing, neglecting, dents by a court of law; or entered into the State concerning abuse, neglect, sidents or misappropriation			
	of their property; a has of actions by a employee, which v	nd report any knowledge it a court of law against an vould indicate unfitness for			
		aide or other facility staff to de registry or licensing			
	violations involving abuse, including ir and misappropriat reported immediat the facility and to c with State law thro	nsure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are ely to the administrator of other officials in accordance ough established procedures tate survey and certification			
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.			
	reported to the adding representative and accordance with S State survey and controlling days of the state state state survey and controlling days of the state state state.	nvestigations must be ministrator or his designated of to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective en.			
		ew and record review, the	F0225	F 225	04/24/2011
	_	ensure an allegation of			
	verbal abuse was			What corrective action(s) will	be
	-	diana State Department		accomplished for those residen	nts
	of Health for 1 of	f 1 residents in a sample		found to have been affected by	the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY			
		IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
		155243	B. WING 04/20/2011					
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	-		
				300 WINDY HILL DRIVE				
REGENO	CY PLACE OF LAFA	YETTE		LAFAYE	ETTE, IN47905			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	of 9. (Resident I).				deficient practice?			
					Resident I was assessed on 4/18	0/11		
	Findings include	:			by the DNS for signs and symptom			
					of anxiety or distress related to	II		
	A handwritten no	ote, dated 3/30/11,			incident reported on 3/30/11. T	II		
	documented as a	resident interview as part			resident did not exhibit any sigr	II		
		stigation by the SSD			distress or anxiety related to the	;		
		Director), indicated			incident reported on 3/30/11.			
	`	(NA #1) left her on the			The ineliant new of the 2/20/1	1		
	· ' '	<i>'</i>			The incident reported on 3/30/1 reported to the Indiana State Bo			
	bed pan and yelled at her. She doesn't want (CNA #1) around her. Happened several nights recently"				oaru			
					of Health on 4/18/11.			
	severai nignis rec	centry			How other residents having th	e		
					potential to be affected by the			
		ical record was reviewed			same deficient practice will be	l l		
		0 P.M. The record			identified and what corrective			
	indicated the resi	dent was admitted with			action(s) will be taken			
	diagnoses which	included, but were not			to be			
	limited to, anxiet	y, dysphagia, and						
	cerebrovascular a	accident.						
					What measures will be put in 1			
	A Minimum Data	a Set (MDS) assessment,			or what systemic changes will	II		
	dated 4/8/11, ind	icated the resident was			made to ensure that the deficie	ent		
	moderately impa	ired in cognitive			practice does not occur			
	1 .	skills, was able to recall			The Director of Nursing,			
	ľ	required extensive			Administrator and Director of S	Social		
		-			Services have been re-educated	on		
one-person assistance for bed mobility and transfer, and was totally dependent on				the policy and procedure on				
	one-person physical assistance for toilet				identifying, reporting, protecting	g a		
					resident and investigating an			
	use.				allegation of abuse.			
	Tukam : 4/1/	0/11 -4 10.50 D.M. '.1			How the corrective action(s) w	rill		
		8/11 at 12:50 P.M., with			be monitored to ensure the			
		ursing Services in			deficient practice will not recu	r,		
	· ·	Resident #I indicated			i.e. what quality assurance			
	CNA #1 yelled at	t her when she was on the			program will be put into place	,		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155243	B. WIN			04/20/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		300 WINDY HILL DRIVE				
REGENCY PLACE OF LAFAYETTE					ETTE, IN47905		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
		er she had to get off in ten			A Performance Improvement to	ol has	
	minutes."				been developed that will monitor		
					facility compliance of abuse Po		
		8/11 at 12:55 P.M., with			& Procedures. The Administrat		
	the DNS indicate	ed the incident was not			and/or designee will complete to		
	ı	eported to the Indiana			weekly. Findings will be report		
	State Departmen	t of Health. She stated "I			the PI team monthly for 3 mont and then quarterly to ensure ong		
	misread the inves	stigation."			compliance.	going	
	Interview on 4/18/11 at 1:00 P.M., with				Findings and system componen		
	the Social Servic	e Director indicated			be reviewed by the Performance		
	Resident #I told 1	her CNA #1 had yelled at			Improvement Team with subsequent		
	her regarding being on the bedpan.				plan of correction developed an implemented as deemed necessal		
	Review on 4/18/	11 at 1:15 P.M. of a					
	facility policy an	d procedure, dated					
	7/22/10, provided	d by the Staff					
	Development Co	ordinator, and titled					
	"Responding to a	and Investigating an					
	Abuse Allegation	n" indicated "For All					
	Abuse Allegation	nsBegin an internal					
	investigationRe	eport the alleged abuse to					
	the appropriate s	tate agencies in					
	accordance with	state law"					
	Review on 4/18/11 at 1:15 P.M., of a						
	facility policy an	d procedure, dated					
	6/30/06, provided by the Staff Development Coordinator, and titled "Conducting an Investigation" indicated						
	1	ntion requires a center					
	1	at all allegations of					
	abuse, neglect, ar	-					
		appropriation, including					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243	(X2) M A. BUII B. WIN	LDING G	NSTRUCTION 00	(X3) DATE COMPL 04/20/2	ETED		
	NAME OF PROVIDER OR SUPPLIER REGENCY PLACE OF LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WINDY HILL DRIVE LAFAYETTE, IN47905					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	findings to the S within 5 working	own source, are stigatedSubmit the tate Survey Agency a days of the initial cate regulations, if							